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ABSTRACT

Text, illustrations, and exercises are utilized in this set of four learning modules designed to instruct nurses and nursing students in writing objective clinical reports. The first module, "Nursing Notes in POMR" by Roberta L. Andrews, discusses the four components of a nursing report written under the Problem-Oriented Medical Record System: patient comments; objective clinical observations, such as the pulse rate; the nurse's assessment of the patient's condition; and plans for following up on this assessment. The second module, "Patient Condition Reporting" by Malcolm MacDonald, discusses the writing of patient reports which include personal identifying information, immediate and long-range nursing needs, treatment order changes, equipment requirements, and environmental factors such as desired room temperature. The third module, "Incident Reports" by Gerry Kenny, defines incidents as accidents, thefts, or other abnormal occurances; examines methods of avoiding hearsay and subjectivity in describing incidents; and follows an incident report through channels. The fourth module, "How to Chart Nurses' Notes" by Kathleen M. Hopkins, discusses the writing of clear, unambiguous clinical observations of patients' health and behavior. Each of the modules provides reinforcement exercises with immediate feedback and concludes with a post-test and answer key. The modules require from 15 to 40 minutes to complete. (JP)

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HEALTH INSTRUCTION PACKAGES

RECORD-KEEPING IN ALLIED HEALTH

Modules prepared by:

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NURSING NOTES IN THE POMR

by

Roberta L. Andrews, M.S.N

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INTRODUCTION

In the past, the writing of nurses' notes has been perceived as a thankless, senseless, and time-consuming task. Comments from nursing personnel would sound like this: "nobody reads them," "nothing new happened to the patient," etc.

However, things are changing. With the Problem-Oriented Medical Record System being used, nursing and nurses' observations about patients play a vital role in the overall plan of care. Nursing personnel are now expected to write meaningful notes which fit into the total picture of identifying and solving patients' problems.

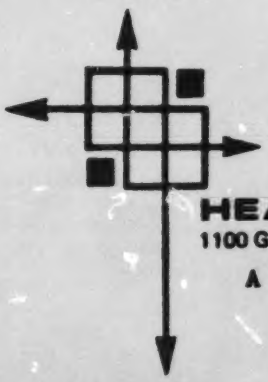
The completion of the package will enable you to logically relate and record what the patient says and does - and what you see, feel, smell, touch and hear - to specific problems and treatments that have been planned for the patient. This will enable you and other members of the health team to give better patient care.

The objective of this learning experience is that:

You will write nurses' notes in the S.O.A.P. Manner based on data obtained from a patient.

TITLE:	Nursing Notes in the POMR
AUTHOR:	Roberta L. Andrews, M.S.N.
INSTITUTION:	North Carolina Memorial Hospital, Chapel Hill, N.C.
INTENDED STUDENTS:	Nursing
ESTIMATED WORKING TIME:	30 minutes
MATERIALS NEEDED:	None
REVISED:	July 1, 1977

NOTE: This package should be used in conjunction with "The Problem-Oriented Medical Record (POMR): Background Information," by Rita J. Kubicki, which is also available through the HEALTH INSTRUCTION EXCHANGE.



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We shall first look at what the initials S.O.A.P. stand for -- (they don't refer to the product with which we wash.) Instead, they refer to the types of information that you want to collect and record concerning a patient's specific problems.

Specifically they mean:

S - subjective data

O - objective data

A - assessment

P - plan of care

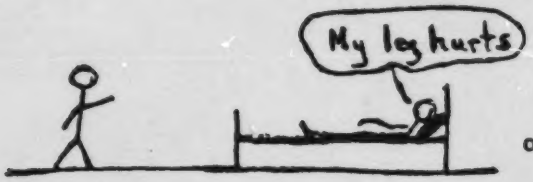
1. See if you can now recall what each of the letters stand for

   1) S =
   2) O =
   3) A =
   4) P =

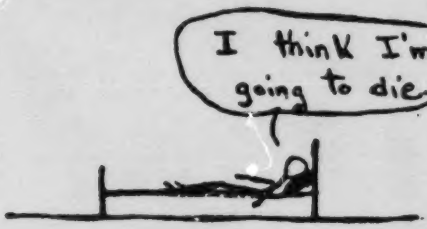
You are correct if you answered 1) subjective data
2) objective data
3) assessment
4) plan of care

Let's look at each initial individually and be certain you know what they mean.

Subjective data is what the patient experiences, thinks, or feels. For example -- a patient may say to you



or



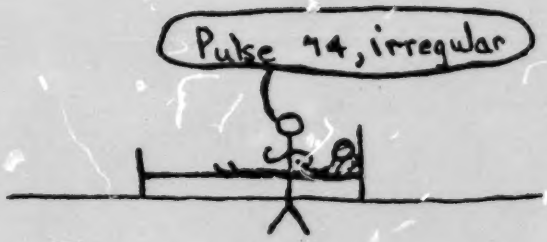
Subjective data is that information about a patient that you have no way of knowing unless he tells you about it.

Objective data is that which you as a member of the health team see, feel, hear, taste or smell about the patient and his environment. Examples of this type of information would be:

Ketodiastix

or

Urine +1 negative



Objective information is what you observe about a patient and his situation. Subjective information is what the patient himself experiences and feels.

2. Try classifying the following information as either subjective (S) or objective (O).

1) _____ B.P. 140-90

2) _____ dressing dry

3) _____ slept at short intervals

4) _____ I have a toothache

5) _____ skin warm and moist

6) _____ my chest hurts

7) _____ I'm scared of surgery

The intended answers are:

1) O - you heard and measured the B.P. reading

2) O - you observed

3) O - you observed

4) S - patient feels this and reports

5) O - you felt his skin

6) S - patient experiences this

7) S - patient experiences this

3. Good, now you know the difference between subjective and objective data. Write in below at least two (2) examples of each from your own experience.

Subjective	Objective
1)	3)
2)	4)

So far we've looked at the S (subjective) and O (objective).

Now let's examine the A in SOAP.

4. This stands for _____

That's correct -- Assessment.

Assessment refers to what you think and feel about what the patient has told you (subjective data) and what you have observed (objective data). In other words -- "What you think is going on in relation to the patient's problem."

Let's look at an example :

Problem #1 -

Nausea and Vomiting

S - reports "I'm hungry"

O - on clear liquid diet -- has had no vomiting for 24 hours.

A - tolerating clear liquids well

Now try it on this situation. Patient's problem #2 Diabetes. He reports to you that he can't affort to buy the dietetic food that he's been getting while in the hospital. You note that he is on a 1800 calorie diabetic diet and his only means of financial support is a Social Security check each month.

5. Fill in the information asked for on the nursing note sheet provided (next page) and give your assessment of the problem.

NURSES OBSERVATIONS

Date	Hour	Observations
		Problem #
		S -
		O -
		A -
		P -

Your notation might look like this:

Problem #2 - Diabetes

S - "can't buy the dietetic food like I've been eating here"

O - on 1800 calorie diabetic diet -- eats well; Social Security check only means of support

A - needs diet instruction and possible financial counseling or aid (words expressing the same ideas)

Assessment -- or drawing conclusions about what we think is happening occurs all the time, frequently without us thinking about it. It is important that we think of it consciously in relation to a patient's problem as this is what makes the logical link between the data and the plan.

The P refers to the plans you have in relation to following up your assessment of the problem.

It usually includes items in regards to:

1) diagnostic measures, i.e., sending a specimen to the lab or testing of a urine on the unit.

2) treatment measures -- such as elevating the head of the bed or administration of a medication -- or continuation of present treatments.

3) patient education measures — such as teaching patient how to deep breathe or exercise; how to test a diabetic urine.

The three elements that may be included in the plan for a patient are:

1) diagnostic -

2) treatment -

3) patient education -

6. Write in above at least two more examples of each element.

Some of your answers might have been -

1) monitoring of TPR, BP, EKG tracings, occult blood test

2) changing of dressings, wet soaks, bathing, mouth care

3) diet instruction, instruction regarding home care

7. Now let's try the plan out on one of the previous patient problems we talked about before. On the same sample nurses' notes that you wrote for the patient with the diabetic problem — write out <u>your</u> plan of care for the same patient.

Your answer for P should contain elements similar to the following:

Patient education -

1) call (ed) dietician regarding diet instruction and types of inexpensive food he might substitute in diet.

Treatment -

1) social worker (Mrs. _____) will visit regarding financial situation

2) will refer to Public Health Nurse upon discharge.

Look over what you have on your nurse's note. Doesn't that tell you and <u>others</u> a lot more about the patient and what is being done for him than the previous narrative nurses' notes we used to write? I hope your answer is yes.

You and other health team members will now be able to see the patient's problems -- their relationships and his progress much more easily than before.

POST-TEST

1. Select one of the patients to which you are assigned.
2. Read over and become familiar with the Problem List on his chart.
3. Administer A.M. Care to the selected patient (no time limit).
4. Write sample nursing notes on the patient related to one or more of his specific problems. Follow the format you used in this package in writing the notes.

   When you have completed the notes discuss them with your Team Leader, who will review and help you evaluate them.

POST-TEST ANSWER KEY

The author hopes that you were able to complete 1-4 to the satisfaction of yourself and your instructor/team leader.

Good luck in using your new skill.

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PATIENT CONDITION REPORTING

By

Malcolm MacDonald

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TITLE OF PACKAGE:	Patient Condition Reporting
AUTHOR:	Malcolm R. MacDonald
INSTITUTION:	Bakersfield College, Bakersfield, Calif.
INTENDED STUDENTS:	Nursing (A.D.N.)
ESTIMATED WORKING TIME:	40 minutes
MATERIALS NEEDED:	None
REVISED:	August 1, 1977

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OBJECTIVES OF UNIT

Overall Objective

After you have completed this unit, you will be able to give total and complete information in a report.

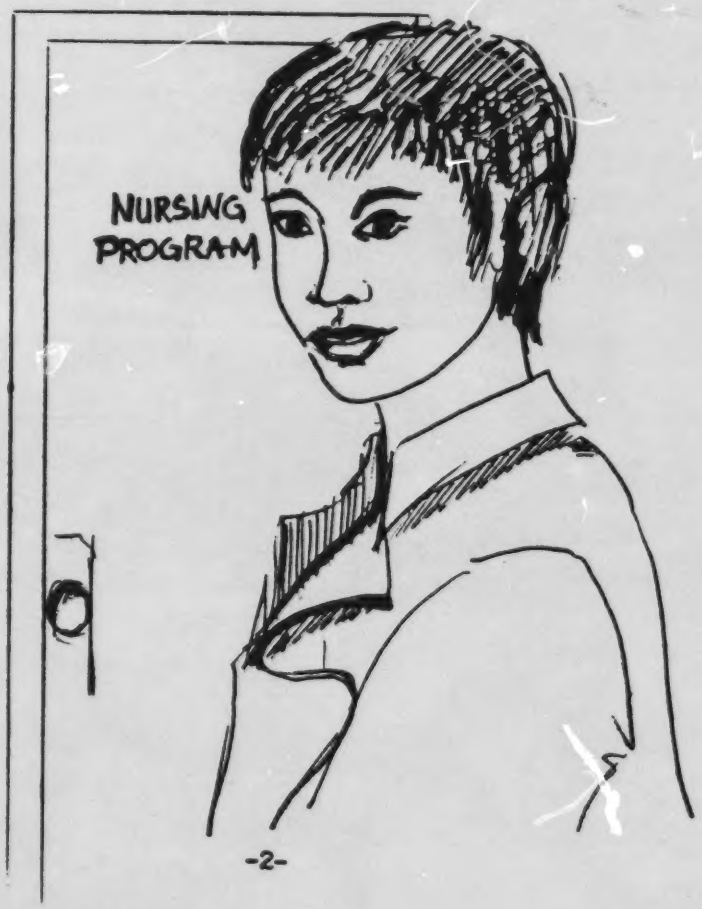
Sub-Objectives

1. You will be able to relate fundamental principles of communication to the reporting process.

2. You will also be able to describe components of the report, including:

   A. Identifying information
   B. Immediate nursing needs
   C. All-day and long range nursing needs
   D. Treatment order changes
   E. Equipment
   F. Environment

NOW TURN THE PAGE AND LET'S GET STARTED



-2-

Reporting the current status of patients is essential for patient care planning. The report should assure continuity of care and safe nursing practice. Yet are you sometimes frustrated by the report you receive? Perhaps even more, are you dissatisfied with the report you give? How do you know you have "covered everything?"

This short instructional package will help you formulate your reports. Practicing the skills of reporting will provide you with confidence, but most important, will contribute towards quality patient care.

The purpose of a patient condition report is to impart critical information which will prepare the oncoming personnel for their responsibilities. Since this is a method of communication, basic principles apply to the reporting process. Keep these principles foremost in your mind as you prepare and give the report. These are key guidelines.

BE PROMPT AND PREPARED. A report of 25 "typical" medical-surgical patients should be no longer than 25 minutes. Reporting requires only accurate and relevant information. Have this, in writing, at your fingertips. Don't rely on your memory. The amount of information nurses must report can be overwhelming. Start the report on time, and allow minimal distractions or interruptions. Remember, your report is vital for good patient management.

BE IN CHARGE OF THE REPORT. Remember this is YOUR report. You are imparting critical information. Interruptions must be kept minimal, and only if truly pertinent to the report. You are in charge. However, if your report is accurate and concise this, in itself, will minimize need for questions.

DEVELOP A ROUTINE. Organizing the report reduces errors that may result from forgetting. Develop a report format. Keep the format in front of you throughout the report until it is memorized. A format (or outline) is provided for you in this learning package!

RELATE CHANGES SPECIFICALLY. Be sure to specify changes in patient condition. Include a bio-psychosocial assessment which indicates improvement or retrogression. Changes in treatment orders or nursing approaches need to be related carefully. This need not be lengthy, but must be all-inclusive.

KEEP THE REPORT ON A PROFESSIONAL LEVEL. Information should be limited to information relating to the health-illness status of the patient. There is no place for gossip in nursing, certainly not during a report. You set the atmosphere for the report. Carefully chosen descriptive words should be used to relate the patient's condition and needs meaningfully to the oncoming personnel.

You especially need to be aware of the feelings, negative and positive, that you are instilling throughout your report. The report must not be viewed as an opportunity to shed inner frustrations that may have occurred throughout your tour of duty.

Practice Question #1

You have reviewed communication principles which should be employed as guidelines for reporting. Match the following incidents to the principle which you feel is most appropriate.

Incident		Principle
_____ a)	A nurse reports that Mrs. James' I.V. of 5% Dextrose in Distilled Water is to be maintained at 30 qtts/min. throughout the next 8 hours.	1. Be Prompt and Prepared 2. Be in Charge of the Report 3. Develop a Routine 4. Relate Changes Specifically 5. Keep a Professional Level
_____ b)	An aide expresses, angrily, "another 15 minutes wasted. I sure wish we'd start on time. Report's such a waste of time!"	
_____ c)	During a between shift report, the nurse says, "Did you know 202b's been looking for a new husband?"	
_____ d)	During report the three aides are discussing last night's party with the L.V.N.'s. No one really seems to pay attention to the report.	

(Turn the page for the correct answers.)

A. 4

B. 1

C. 5

D. 2

If you had difficulty with applying these basic principles of communications to the reporting process, please refer to:

Kron, Thora. The Management of Patient Care. Philadelphia: W.B. Saunders Co., 1976, p. 155-158.

One of the principles we discussed was "Develop a Routine." There is critical information that must be included for each patient status report. When you are organized to the point that each list of information has been presented you will be confident that your report is complete. Now, then, let's look at the critical components of the patient condition report.

IDENTIFICATION INFORMATION. This includes:

1. Name
2. Age
3. Room, number and bed number
4. Doctor's name
5. Diagnosis
6. Post-operative day, or hospitalization day

Isn't that easy to remember?

Let's see.

SAMPLE KARDEX

323 B
John Smith M-32
Dr. Singleton

DIAGNOSIS:
Myocardial/Infection 12-12-7(
SURG. PROCEDURE:
By-Pass (Coronary) 12-22-7(

HOSP. DAY: (daily) P.O. DAY (daily)

DOCTOR: Singleton

(Write these in ✎ pencil, so they can be erased by clerk)

DIET:

SPECIAL INSTRUCTIONS: BP (on Adm) TPR (on Adm) I-O Bath Wt.

ACTIVITY:

DATE	MEDICATIONS:	AM	PM	D/C DATE	DATE	LAB/DIAGNOSTIC PROCEDURE	DATE TO BE DONE
	(Keep these current)						

DATE	TREATMENTS:	AM	PM
	(Keep these current.)		

ALLERGIES:

SPECIAL COMMENTS:

LAX

Last BM

#	IV FLUIDS	HOURS TO RU

Practice Question #2

The above is an example of a Kardex. From it specify the identifying information.

_____

_____

_____

_____

(Turn the page for the correct answer.)

"John Smith, 32, 323^{B}, Dr. Singleton, Myocardial Infarction, tenth post operative day."

Did you forget any information?

If you are having difficulty remembering all the identifying information, simply write out the information and use it as a guideline for your report.

For example:

1. Name
2. Age
3. Room number and bed number
4. Doctor's Name
5. Diagnosis
6. Post operative day/hospital day

IMMEDIATE NURSING NEEDS are the next component of the report. Generally you can use the following as a checklist to assure completeness of the report.

1. General Condition: improved, retrogression, the same, color, skin condition, edema, dyspnea, diaphoresis, etc. Relate to medical and nursing diagnosis.

2. Vital Signs: current, variation, changes.

3. Pain: latest pain medication, other relief.

4. Bleeding and/or Drainage: dressings, packs, etc.

5. Medications: increase, decrease, changes needed.

6. Treatments: new orders, responses, IPPB, Heat, Cold, IV (report type, rate, present level), I&O, etc.

7. Tests: sputum, X-ray, laboratory, fasting, Nurses' responsibilities.

Practice Question #3

What immediate nursing needs would you report on the following patient?

John Smith	32	Myocardial Infa Coronary By-Pass	Patient Description: Throughout your 8 hr. shift ambulated first time. Dr. Singleton removed chest tubes and discontinued I.V. Difficulty coughing, yet seems more congested. IPPB ordered by Dr. Singelton One treatment given.

(Turn to the next page for the correct answer.)

You should report:

1. ambulated - how far? how tolerated?

2. chest tubes removed - do not remove dressing which covers puncture wound. - caution staff to observe for signs of pneumothorax.

3. I.V. discontinued - increase fluid intake - relate fluid preferences

4. congestion - describe helpful coughing methods and coughing and deep breathing routine.

5. I.P.P.B. - times ordered? medications? response to?

In addition you would need to report the other immediate nursing needs information relating to this patient. For example, general condition, vital signs, pain, tests.

If you had difficulty with this practice question, develop an Immediate Nursing Needs Checklist (use the 7 components) and apply them to 5 or 6 patients assigned to you. You will develop a routine for reporting.

GREAT, YOU HAVE ACCOMPLISHED THE SECOND COMPONENT OF REPORTING.

In order to provide the oncoming personnel with a total perspective of the patient's condition, they need information relating to the patient's shift activities. These should be related to the short-term and long-term patient care goals which have been identified through the nursing process. Aspects of the patient's condition which you need to report in this area would relate to:

Shift Activities

1. Diet: changes, NPO, preferences, dislikes
2. Elimation: Problems/irregularities, concerns and nursing actions.
3. Comfort Needs: response to nursing goals and efforts you may have tried.
   - discharge plans
4. Educational Needs: what the patient learns about his/her care.
5. Psychosocial Concerns: response to hospitalization, treatment, illness, diagnosis, etc.

In addition to giving a report of the patient's shift activities and needs, the oncoming nursing personnel need information relating to special equipment and environment. You need to report:

Equipment

1. Oxygen: method of administration, flow rate, frequency used on your shift, safety precautions taken, humidity.
2. Suction: type, Gomco, Hemovac, underwater seal, etc.
3. Special Equipment: traction, casts, braces, prosthesis, chairs, lifters, etc.

ENVIRONMENT

1. Temperature, light, sound - idiosyncracies.
2. Housekeeping and bedside equipment.
3. Odors - method of control, cause.
4. Safety - precautions taken and need to maintain.

Practice Question #4

List the categories which are included in a report of a patient's condition relating to the shift activities, equipment and environment needs.

Shift Activities

1) _____

2) _____

3) _____

4) _____

5) _____

Equipment

1) _____

2) _____

3) _____

Environment

1) _____

2) _____

3) _____

4) _____

(Turn page for the answer.)

Shift Activities

1) Diet
2) Elimination
3) Comfort needs
4) Educational needs
5) Psychosocial Concerns

Equipment

1) Oxygen
2) Suction
3) Special

Environment

1) Temperature, light, sound
2) Housekeeping
3) Odors
4) Safety

Did you list them all? If not, don't worry. Use the above as a check list to be used as the step in developing your patient conditions final report.

Now you are ready to put your skills and knowledge of reporting to work. In completing the final practice question it will be helpful if you have developed a checklist of the essential components of a patient condition report. Remember, it is not expected that you will be able to give a complete report as outlined in this learning package without the checklist. The routine will become automatic as you practice reporting.

Practice Question #5

Here is your final practice question: Develop a report on the following patients.

Mrs. A is a 50-year-old patient of Dr. X admitted to 325a three days ago with thrombrophlebitis. On your shift she was on bedrest, received continuous warm saline packs to her left leg, received her heparin via I.V. lock, and rested quietly most of the day.

Mr. B. is a 26-year-old patient of Dr. Y admitted to 326a with appendicitis. He had an appendectomy this a.m. He returned from surgery on your shift.

Mr. C is a 76-year-old patient of Dr. Z admitted to 326b three weeks ago with a C.V.A. He has a left hemiparesis. The primary nursing goal is to rehabilitate to his optimum level of activity. An Occupational Therapist visited on your shift.

Mrs. A. _____

_____

_____

_____

_____

Mr. B. _____

_____

_____

_____

_____

Mr. C. _____

_____

_____

_____

_____

(Turn the page for the answers.)

Your report should include pertinent information relating to

1. Identifying information
2. Immediate nursing needs
3. Short term and long term nursing needs
4. Special equipment
5. Unique environmental needs

The following is an example of a report. Additional information relating to these patients would also be reported. For example, all new or revised physician orders, additional nursing goals identified on your shift, psychosocial responses and needs, etc.

The Report

"Mrs. A, 50, 325a, Dr. X, thrombophlebitis, 4th hospital day, remained on bedrest, continuous warm saline packs with aqua pad - tolerated well, received 5000 units of heparin by I.V. lock, had a restful shift (day, p.m. or noc.)."

"Mr. B., 26, 326a, Dr. Y., Appendectomy today, returned from surgery at _____. (You then would give a post operative assessment, i.e., relate new orders, vital signs, dressing check, pain, deep breathing and coughing routine, ambulation, voiding.)"

Mr. C, 76, 326b, Dr. Z, C.V.A. with left hemiparesis, 22nd hospital day (relate specific immediate needs, eg. diet, elimination, skin care, relate your shift activities to nursing goals of rehabilitation. Response to Occupational Therapist.)

POST-TEST

In order to develop skill in reporting patients' condition completely you need practice. Select a group of patients from your clinical assignment and develop a report. Write the report and ask a team leader, head nurse or your instructor to validate the report. Remember, you need to focus on accuracy, conciseness and completeness.

The skill of patient condition reporting is similar to many other nursing responsibilities. Practice makes perfect! When you feel assured that you are leaving your patients with a staff that has been thoroughly informed of their duties, you will know you've achieved the central purpose of this learning package. Most significant, however, is the fact that your efforts have contributed to the quality of care for patients.

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INCIDENT REPORTS

By

Gerry Kenny

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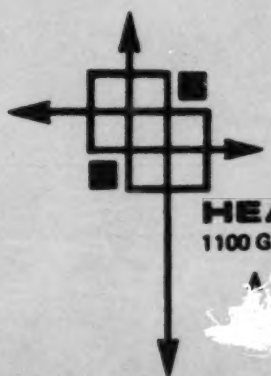
TITLE OF PACKAGE:	Incident Reports
AUTHOR:	Gerry Kenny
INSTITUTION:	Saginaw General Hospital, Nursing Staff, Saginaw, Mich.
INTENDED STUDENTS:	Hospital employees
ESTIMATED WORKING TIME:	15 minutes
MATERIALS NEEDED:	None

FIELD TEST COPY



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INTRODUCTION

Incidents happen in the work situation. That's a fact. We practice safety and follow standard procedures, but incidents still happen.

When they happen, they must be reported and recorded. One reason for reporting is so that all incidents may be investigated. Hopefully, through good reporting and investigating, we can eliminate most of the causes of incidents and make their occurrence less frequent. Another reason for a written report is the legal reason. If a patient elects to sue the hospital, the hospital needs the facts of the incident clearly spelled out where time cannot dim memories. It is everyone's responsibility to complete Incident Report Forms. This package was designed to help make the reporting more accurate and less painful. If you've ever had problems knowing what to put down, try this for help.

OBJECTIVES OF UNIT

Overall Objective

The hospital employee will use the Incident Report Form correctly.

Sub-Objectives

He will:

- define incident
- give three examples of an incident
- state the difference between fact, hearsay and assumption
- follow the incident report through the channels
- will relate how the incident is also recorded in the nurse's notes
- recommend this package for others

PRACTICE EXERCISE #1

"An incident is any happening which is not consistent with the routine operation of the hospital or the routine care of a particular patient. It may be an accident or a situation which might result in an accident."

Most of the things we do in the hospital are pre-planned. When something happens that was not planned for or is not consistent with hospital policy, we call this an incident. If the term reminds you of the word accident, you have another clue to its meaning.

The patient is found sitting on the floor. Patients are usually in beds or chairs.

Dentures were discovered in the bottom of the linen bag: Dentures belong in denture cups when not in patient's mouth.

Mrs. Jones medications were given to Mrs. Smith. They are roommates, but Mrs. Jones has high blood pressure and Mrs. Smith has low blood pressure.

PRACTICE QUESTION #1

Keeping these things in mind, would you define incident and give me three examples of incidents.

FEEDBACK

If you said an incident is an accident or near accident, you are correct. You could have further defined incident as any happening that wasn't planned, or, in the hospital setting, any happening that is not consistent with hospital policy.

Examples of incidents are: patient falls, medication errors, lost dentures, missing radios, misplaced coats, slips on wet floors, wrong treatments, nasty nurses who cause patient complaints.

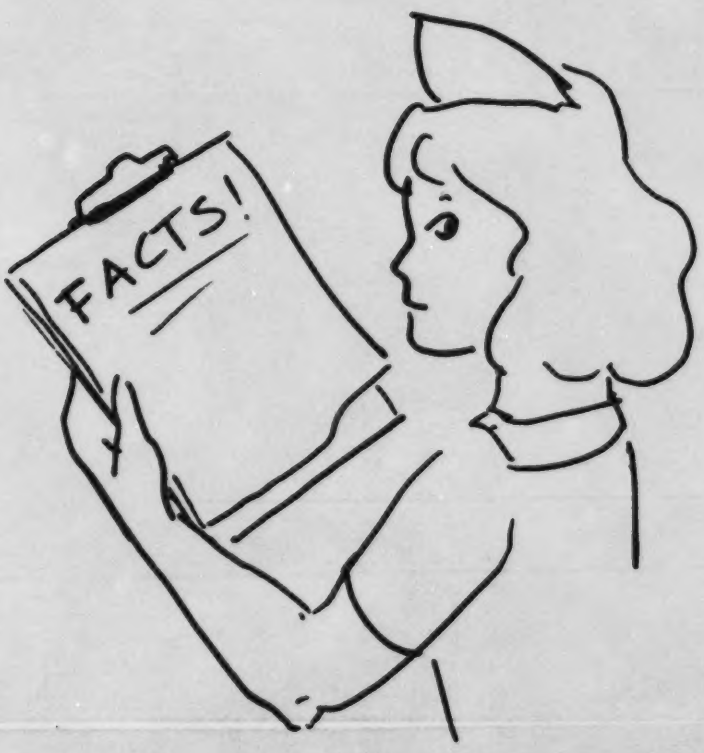
Now that you're on the incident track, I'll bet you can remember some incidents that have occurred. You, also, probably know that when an incident has occurred someone must file an Incident Report Form. If that someone is you, there are certain things you must know to use the form correctly. Incident Reports are usually not fun to do, but they are important. You want to know how to do them right?

Lead on Sherlock ----------

PRACTICE EXERCISE #2

The incident report is interested in facts, "I want facts, just facts", it says. A fact is what you see, what is now. "The patient is on the floor." That's a fact. "Mr. Johnson says the patient fell." That's hearsay. Hearsay is permissable in the incident report if you state "Mr. Johnson says". "Mr. Fallalot is on the floor, he must have fallen." That's assumption. Assumption has no place in the incident report. If you're tempted to use assumption, be sure you label it as an assumption.

Once again, fact is what you see, hearsay is what someone tells you, and assumption is what you think happened. The incident report is interested in facts!



PRACTICE QUESTION #2

Label the following statements as fact(F) or hearsay(H).

Label those that show assumption(A).

a. _____ Mrs. Smith says her watch was stolen.

b. _____ Mrs. Smith's watch is missing.

c. _____ Mr. Fallalot was found sitting on the floor.

d. _____ Mr. Fallalot has no visible bruises.

e. _____ Mr. Johnson states Mr. Fallalot fell over the foot of the bed.

FEEDBACK

Your answers should be:

a. Hearsay - Assumption

b. Fact

c. Fact

d. Fact

e. Hearsay

The facts are: the watch is missing, the patient is on the floor, and there is no visible sign of bruises.

The hearsay is that Mrs. Smith says and Mr. Johnson states, but the assumption of Mrs. Smith is the watch was stolen. The facts may lead you to believe the watch was stolen but at this point, you don't make the assumption, you just

State the Facts!

Is that how you see it now?

PRACTICE EXERCISE #3

Fine, because now that we agree on what an incident is and how it just contains facts, you need to know where the report goes after you've poured your heart and soul into it. You, the Staff Member, have initiated it. The incident occurred in your unit, so your Head Nurse is going to be interested in what has occurred in the hope it may be prevented from happening again. The Nursing Supervisor needs to be kept informed as she is responsible for investigating to determine what the cause of the incident is and to initiate actions to remove the cause. Nursing Office gathers all nursing incidents to see if there is a universal problem that may be remedied by training. The Assistant Administrator reviews all hospital incidents and brings the more serious ones to the attention of the Hospital Lawyer for legal advice.

PRACTICE QUESTION #3

Please number the following as the route the Incident Report takes:

_____ Nursing Supervisor

_____ Staff Member

_____ Head Nurse

_____ Assistant Administrator

_____ Nursing Office

_____ Hospital Lawyer

FEEDBACK

You were correct if you numbered your answer this way:

1. Staff Member
2. Head Nurse
3. Supervisor
4. Nursing Office
5. Assistant Administrator
6. Hospital Lawyer

Did you notice that the Incident Report Form is not made out in duplicate? This means there is only one copy and I have just said that copy remains with the Assistant Administrator at the call of the hospital lawyer. Are you thinking "What about the patient's chart?" "Everything that happens to the patient belongs in the nurses' notes", you say?

PRACTICE EXERCISE #4

Right!!

It should be recorded in the nurses' notes. The incident should be recorded. Just as you recorded it on the Incident Report Form. The time the incident occurred, the why and how of the incident, the patient's reaction to the incident, the fact that the physician was notified should be recorded. The only statement you don't record is the statement that an incident report form has been filled out.

PRACTICE QUESTION #4

For practice, choose the correct responses from these below:

The following information should also be recorded in the nurses' notes:

a. the time of the incident

b. that an incident has occurred

c. that an incident report was filled out

d. the why and how of the incident

e. the patient's reaction to the incident

f. the time the physican was notified

FEEDBACK

All of these are correct responses except C. You should not make the statement in the nurses' notes that an incident report has been filled out.

Congratulations! You've stayed with the package this far. Just one more exercise and you're ready for the big one.

PRACTICE EXERCISE #5

You can recognize an incident when one happens. You know where it is recorded, who needs to have the information and you know how to report the facts. Let's have another try at reporting the facts.

PRACTICE QUESTION #5

Just for practice, rewrite the following statements as they should be entered on the incident report form.

1) Mrs. Jones' watch was stolen from the bedside stand.

2) Mr. Fallalot fell from his bed.

3) Mr. Fallalot was not hurt in the fall.

FEEDBACK

Check your statements with these:

1) Mrs. Jones states her watch is missing.
2) Mr. Fallalot was found lying on the floor at the foot of the bed.
3) Mr. Fallalot has no visible signs of injury.

You've done just great. Thanks for seeing this through and here's hoping all your incidents are little ones.

Please do the Post Test now.

Please do not write on this page - Use the Answer Sheet.

POST TEST

1. Define incident.

2. Give three examples of an incident.

3. State the difference between fact, hearsay, and assumption.

4. Follow the incident report through channels.

5. What information is also recorded in the nurses' notes?

6. Using the Incident Report Form attached, complete it for the following incident:

   You are sitting at the nursing station and you hear a noise from the patient room. You investigate and find Mr. Fallalot on the floor at the foot of his bed. His roommate, Mr. Johnson, says he fell over the foot of the bed. Add any other information necessary and fill out the incident report.

7. This self-instructional package was:

_____Interesting	_____ Boring
_____Important	_____ Irrelevant
_____Clear	_____ Confusing

POST TEST ANSWER KEY

1. An incident is any happening which is not consistent with the routine operation of the hospital or the routine care of a particular patient.

2. Your examples will be different, but you can compare them to these to check yourself: The patient is found sitting on the floor. Dentures were discovered in the bottom of the linen bag. Mrs. Jones' medications were given to Mrs. Smith, they are roommates, but Mrs. Jones has high blood pressure and Mrs. Smith has low blood pressure.

3. Fact - what you see

   Hearsay - someone tells you

   Assumption - what you think happened

4. Staff member to
   Head Nurse to
   Supervisor to
   Nursing Office to
   Assistant Administrator to
   Hospital lawyer

5. Time of the accident
   That an accident has occurred
   That an Incident Report was filled out
   The why and how of the incident
   Patient's reaction
   The time the physician was notified

6. See next page

PATIENT - VISITOR - OTHERS

INCIDENT REPORT

"An incident is any happening which is not consistent with the routine operation of the hospital or the routine care of a particular patient. It may be an accident or a situation which might result in an accident."

Thomas Fallalot Rm. 204
Dr. Smith

IF PERSON OTHER THAN PATIENT, PLEASE WRITE IN NAME

LAST NAME ♦ | FIRST NAME ♦ | MID. INIT. ♦

PATIENT ☒ | DIAGNOSIS: Congestive Heart Failure

WERE BED RAILS PRESENT? YES ☒ | NO ☐ | UP ☒ | DOWN ☐ | ORDERED ☒

WAS HEIGHT OF BED ADJUSTABLE? YES ☒ | NO ☐ | UP ☐ | DOWN ☒

VISITOR ☐ | HOME ADDRESS: | HOME PHONE:

OTHER ☐ | REASON FOR PRESENCE IN THE HOSPITAL? | MR. ☐ | MRS. ☐ | MISS ☐ | CHILD ☐ | AGE.....

EXACT LOCATION OF INCIDENT: Room 204

DATE OF INCIDENT: 2/3/77

TIME OF INCIDENT: 10 30 ☐ A.M. | ☒ P.M

DESCRIBE IN DETAIL THE WHAT, WHY, AND HOW OF THE INCIDENT.

I (Geraldine Kenny) was sitting at the nursing station and heard a noise from Rm 204. Upon investigating I found Mr. Thomas Fallalot lying on the floor at the foot of his bed. The roommate (Mr. Joseph Johnson) stated Mr. Fallalot had climbed to the foot of the bed and fell over onto the floor. There were no apparent bruises on Mr. Fallalot. He stated he was not hurt and that he was trying to go to the bathroom. The side rails were up and the bed in low position. Mr. Fallalot was helped back to bed, the urinal placed in bed with him and he was instructed to use the call light and summon the nurse if he needed anything. The bathroom light was left on to help him remain oriented. His vital signs were B/P 110/80, P-80, R-20. Posey belt applied.

NAME, ADDRESS, PHONE NUMBER OF WITNESS(ES)
Mr. Joseph Johnson Ph. 792-0345
3210 Mackinaw - Saginaw

TITLE AND SIGNATURE OF PERSON PREPARING REPORT ♦ | DATE OF REPORT / / | TIME REPORT COMPLETED ☐ A.M. | ☐ P.M

WAS PERSON INVOLVED SEEN BY A PHYSICIAN? YES ☒ | NO ☐ | TIME SEEN: 11 00 ☐ A.M. | ☒ P.M. | WHERE? In Room 204

PHYSICIAN'S NAME: Dr. William Smith | TIME PHYSICIAN NOTIFIED OF INCIDENT: 10 30 ☐ A.M. | ☒ P.M

STATEMENT OF PHYSICIAN: No apparent injuries. Posey restraint may be used.

SUPERVISOR'S REPORT

CAUSE(S) OF INCIDENT:

ACTIONS NECESSARY TO REMOVE CAUSE(S):

SUPERVISOR'S SIGNATURE ♦ | DATE OF REPORT: / /

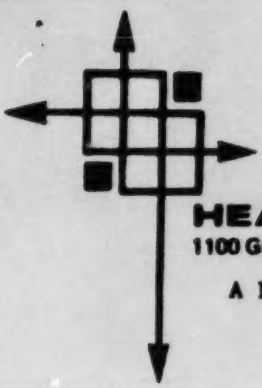
ACTION BY DEPARTMENT HEAD:

DEPARTMENT HEAD SIGNATURE ♦ | DATE OF REPORT: / /

ACTION BY HOSPITAL ADMINISTRATION:

SIGNATURE ♦ | DATE OF REPORT: / /

SEND TO ADMINISTRATION



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A PROJECT OF THE LEAGUE FOR INNOVATION IN THE COMMUNITY COLLEGE

HOW TO CHART NURSE'S NOTES

By

Kathleen M. Hopkins, R.N.

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TITLE:	How to Chart Nurse's Notes Objectively and Descriptively
AUTHOR:	Kathleen M. Hopkins, R.N.
INSTITUTION:	St. Joseph's Hospital and Medical Center, Phoenix, Arizona
INTENDED STUDENTS:	R.N.'s, L.P.N.'s and nursing assistants in nursing orientation as new employees
ESTIMATED WORKING TIME:	30 minutes
MATERIALS NEEDED:	None
REVISED:	November 15, 1977

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INTRODUCTION

One of the essentials of good nursing is the ability to make thoughtful, intelligent patient observations that create a clear, objective and descriptive picture of that patient. The physician often depends on the nurse's alert, accurate observations to make a correct diagnosis and to order or alter treatments.

Data obtained by a nurse's observations might just be the deciding factor in a matter of life and death. Such data is most important in regulating the patient's nursing care to achieve maximum benefit and comfort. The hospital is also able to analyze the quality of care through such carefully recorded observations.

Just what is meant by "Objective Charting"?
How can it be done?
How can you be sure your charting reflects objectivity?

You will learn the answers to these questions as you complete this program.

I hope you will anonymously report your reactions to this program. Your answers will be used to improve the overall unit.

OBJECTIVES OF UNIT

Overall Objective

The nursing student will chart observations of patients using objective, descriptive terms.

Sub-Objectives The student will . . .

1) differentiate between subjective and objective charting terms by listing three examples of each.

2) Identify charting terms that describe observations made via seeing, hearing, smelling and feeling.

3) Given a picture of a patient, write in objective terms what is seen.

4) Report that this unit was of some importance and interest.

A subjective charting statement is one that reflects personal opinion without describing the total picture of events that lead to the opinion It is biased, non-descriptive and doesn't tell you all you need to know about the patient.

Practice Question #1

a. In your own words, write what is meant by subjective charting:

b. Give three examples of subjective charting.

1)

2)

3)

Feedback

If you said words to the effect that subjective charting is a biased, non-descriptive, personal opinion of an observation made about a patient, you are correct.

Now examine your examples of subjective charting.

. . . Do they give you all the information you need to know about what was observed? Your answer should be NO.

. . . Are the statements biased? Non-descriptive? Definitely, YES.

If so..... PRACTICE QUESTION 1 (Continued) .....

C. Take ONE of your examples and rewrite it in descriptive, objective terms. For instance, if you said that "Mr. Ansel is hostile", you may clarify it by rewriting it in objective, descriptive terms by saying: "Mr. Ansel hit his nurse as she repeatedly asked him to refrain from smoking while he is using oxygen."

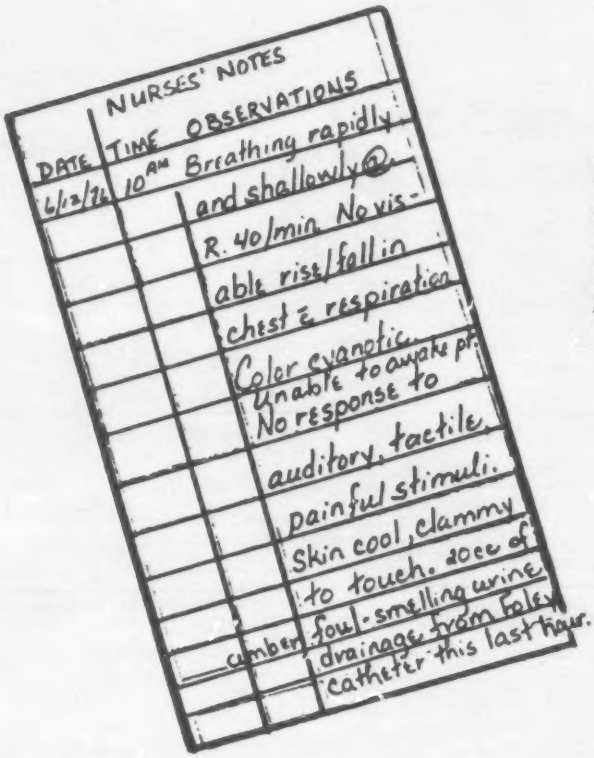
Rewrite your example now in objective, descriptive terms below.

Does it now tell the whole story? ____Yes ____No

If you answered YES, then that's good!

To further clarify what is meant by "objective charting" turn to the next page.

An objective charting statement is one that accurately describes in non-biased, non-judgmental terms what you have observed about a patient.


NURSES' NOTES
DATE
TIME
OBSERVATIONS
6/12/96
10 AM
Breathing rapidly and shallowly @ R. 40/min. No visable rise/fall in chest & respiration. Color cyanotic. Unable to awake pt. No response to auditory, tactile, painful stimuli. Skin cool, clammy to touch. 20cc of foul-smelling urine drainage from foley catheter this last hour.

Note:

Descriptive, objective charting statements give a clear picture of what you see, hear, feel and smell.

Practice Question 2

Situation:

Your patient says she feels like she needs to urinate but has been unable to. Her abdomen is distended and firm to touch. The doctor writes the order to:

1. insert a #21 Foley urinary catheter into bladder
2. connect Foley to continuous straight drainage set-up

In addition you will have to . . .

1. instill 5cc of sterile water into balloon through balloon port after catheter insertion.
2. tape catheter to either the right or left leg.
3. note amount, color and clarity of drainage
4. clamp the catheter if 1000 cc of urine is obtained so as to not allow the bladder to completely empty.

NOW . . .

a. Chart in objective terms what you did and the OUTCOMES of the procedure. (Here's a chance for you to be imaginative!)

Feedback

Does your charting give you information about

. . . . size of Foley catheter inserted? (#21)

. . . . amount of sterile water instilled into the balloon through the balloon port? (5cc)

. . . . amount, color, and clarity of urine drained?

. . . . catheter connected to continuous straight drainage set up?

. . . . catheter taped to right or left leg?

If the answers to the above are YES - good!

On Page 3 you listed three examples of subjective charting. You rewrote one of these examples in objective, descriptive terms on Page 4.

Now . . .

b. Rewrite the remaining two examples of subjective charting in objective, descriptive terms.

1)

2)

EXAMINE YOUR WORK!

are your newly-revised examples . . .

. . . unbiased? Non-Judgmental?

. . .giving you the total picture of what you observed through your senses (of sight, hearing, feeling, smelling)?

I hope your answers to these questions are YES! If so - - good for you!

Up to this point, we have discussed the mechanics of subjective and objective charting. Now let's see how we can observe the patient through our senses of seeing, hearing, touching, and smelling.

Apply the senses one by one, asking such questions as

. . . . What details can I see?	color, drainage
. . . . Can I hear any sounds?	grunting, groaning, sighing
. . . . What does touching the patient tell me?	texture, temperature, wetness, dryness
. . . . If there is an odor, what is it?	discharges, breath, flowers, medications.

Practice Question 3

a. Let's say that you have been requested to observe how a patient's skin feels to you when you touch it. List all the possible observations you might make:

b. Similarly, you have been asked to listen to respiratory sounds expressed by a patient. List all the possible observations you might make. You may or may not choose to include listening to respiratory sounds with a stethoscope.

Feedback

a. If your answers included such objective terms as smooth, bumpy, rough, cool, warm, dry, moist, clammy, etc., then you are aware of how to chart observations made through sense of touch. Congratulations!

b. If your answers included such objective terms as snoring, gurgling, whistling (wheezing), etc. then you indeed are aware of how to chart observations made through the sense of hearing. Good!

Situation:

1 pm. Mrs. Carlson, 40 years old, was just admitted to your unit with the diagnosis of vaginal bleeding. Her doctor has scheduled her for a D & C (dilatation and curettage) at 4:30 p.m. The doctor says that Mrs. Carlson has had heavy vaginal bleeding steadily for the last 12 days. She has also experienced continued weakness, extreme fatigue and pallor.

You have already observed for:

a) vaginal bleeding - color, amount, clots

b) weakness and fatigue

c) skin color

YOUR TASK: NOW. . .

Practice Question 4: Chart your observations in objective, descriptive terms.

a)

b)

c)

Feedback

a) In charting observations of vaginal flow, did you mention . . . . color? amount (i.e., how many sanitary napkins were saturated within a specified length of time?) Did the discharge contain clots? If so, how many?

b) In charting your observations of weakness and fatigue, did you mention. . . Patient's complaints of weakness and fatigue? Patient's activity when observed. Was she able to stay awake, to do personal hygiene, etc.?

c. In charting your observations of skin color, did you mention. . . pallor? absence or presence of make-up?

If your answers to the above questions are YES, congratulations. You are now ready to take the POST-TEST.

POST-TEST

Case Study - Sample Charting

Mrs. Jackson, 36 years old, was admitted two days ago with the diagnosis of gastric ulcer. The sample charting that follows contains both subjective (biased, judgmental) terms and objective terms.

10:40 am	Complains of gnawing, burning sensations in chest and stomach. Nauseated. Belching frequently. Nervous and upset at present. Hostile.
10:43 am	Medicated for gastric distress
11:00 am	Reports that gnawing, burning and nausea sensations have "lessened" since medication.
11:30 am	Ate soft, bland diet. Tolerated well.
12:00	Sensations of gastric distress subsided.
3:00 pm	Nauseated with 30 cc of yellow pink-tinged emesis. Complaining of continuous gnawing stomach pains. Requesting antacid for relief.

(Use the above chart for questions 1 and 2.)

1. List three examples of subjective (biased, judgmental) charting terms. Reword the examples in objective terms

   1)

   2)

   3)

2. List three examples of objective charting terms.

   1)

   2)

   3)

(The following statements are to be used for questions 3-6)

   a. Skin cool and clammy

   b. Gurgling respiratory noises noted in right lung base.

   c. 100 cc of dark green drainage obtained from naso-gastric tube.

   d. Foul-smelling urine noted.

3. Which of the above reflects observations made through the sense of sight? ___

4. Which of the above reflects observations made through the sense of hearing? _____

5. Which of the above reflects observations made through the sense of smell? _____

6. Which of the above reflects observations made through the sense of touch? _____

7. Chart in objective, descriptive terms what you observe about the patient. in the drawing.

8. I have found this package to be:

   Interesting / Important ——— Boring / Irrelevant

9. I will incorporate the information given into my charting procedure.

   Yes _____ No _____

11

POST-TEST ANSWER KEY

1. a) "Nervous and upset at present." Pacing up and down the hall. three cigarettes in 5-minute period. Crying.

   b) "Hostile" Shouting loudly at nurses. Demanding that she immediately be given medication to relieve gnawing, burning sensation in her stomach.

   c) "Tolerated well." Lunch retained with no reports of stomach discomfort.

   d) "Gastric distress." Gnawing, burning and nausea sensations in stomach.

2. a) "Ate soft, bland diet."

   b) "Complains of gnawing, burning sensations in chest and stomach."

   c) "Belching frequently."

   d) "Reports that gnawing, burning and nausea sensations have 'lessened' since medication."

   e) "Nauseated with 30 cc of yellow, pink-tinged emesis."

   f) "Complaining of continuous 'gnawing stomach pains.' Requesting antacid for relief."

3. c

4. b

5. d

6. a

7. Adult man sitting on bench. Shoulders and upper torso hunched forward. Holding half-smoked cigarette in left hand.

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